Patient Registration Form

Patient Name: ___________________________________ Social Security Number: ________________________________

Date of Birth: _______/_______/_______ (MM/DD/YYYY) Sex: ☐M /☐ F ☐Married ☐Single ☐ Divorced/Widow

Address: ____ City: ____________________________ Zip Code:____________

☐ Cell ☐ Home Phone: (______) ____________________ E-mail Address: ____

Would you like to receive text messages? ☐ YES ☐ NO

How did you hear about our practice? ____

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship: ___________________ Phone: (_____) ______________________

INSURANCE INFORMATION

Employer Name: _______________________________ Insurance Company Name: ________________________________

Primary Card Holder Name: ___________________________________ Police holder Date of Birth: _________________________

Member ID: _______________ Group Number :_________________ Insurance Phone Number: (_____) _________________

CONSENT FOR DENTAL TREATMENT

I request and authorize the doctors employed at OC Perfect Smile, to examine, clean, and provide dental treatment on my teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctors to diagnose and/or treat my dental problem. I will allow photographs to be taken on my teeth for diagnostic or educational purposes. I will be responsible for any charges incurred for my dental treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services.

If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. I hereby authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or health practitioners. I authorize and release my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand I am required to take care of any portion not expected to be paid by the insurance at the time of the treatment. If the dental insurance carrier pays less than expected, I understand any remaining balance is my responsibility and I agree to be responsible for payment of all services rendered. I understand that I am responsible for all fees for services rendered. In the event OC Perfect Smile seeks enforcement of this agreement through the services of a collection agency, I shall be responsible for any incidental expenses, including collection costs and reasonable attorney's fees. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

I have read the above conditions of treatment and agree to the content.

Patient, Parent or Guardian Signature: ____ **Date:** _______________

Medical History *Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.*

Are you under a physician's care now? ☐Y /☐ N If yes, last exam date: ____________________________________
Have you been hospitalized or had a major operation? ☐Y /☐ N If yes, please explain: ____________________________________
Have you had a serious head or neck injury? ☐Y /☐ N If yes: ____
Have you ever taken Fosamax, Boniva, Actonel , etc?
Do you use tobacco? ☐Y /☐ N If yes: ____
Do you use controlled substances? ☐Y /☐ N If yes: ____
Do you often doze off or fall asleep while sitting inactive? ☐Y /☐ N
Do you snore? ☐Y /☐ N
Has anyone noticed that you quit breathing when you sleep? ☐Y /☐ N
How often do you feel tired or fatigued after you sleep? ____

For Women only: *Pregnant*☐ *Trying To Get Pregnant* ☐ *Nursing?* ☐ *Taking Oral Contraceptives?* ☐

Please indicate any allergies or reactions to mediations, latex or other: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Y /☐ N	Convulsions	☐Y /☐ N	Hypoglycemia	☐Y /☐ N
Alzheimer's Disease	☐Y /☐ N	Cortisone Medicine	☐Y /☐ N	Kidney Problems	☐Y /☐ N
Anaphylaxis	☐Y /☐ N	Diabetes	☐Y /☐ N	Liver Disease	☐Y /☐ N
Anemia	☐Y /☐ N	Drug Addiction History	☐Y /☐ N	Lung Disease	☐Y /☐ N
Angina	☐Y /☐ N	Epilepsy or Seizures	☐Y /☐ N	Osteoporosis	☐Y /☐ N
Arthritis/Gout	☐Y /☐ N	Epinephrine sensitivity	☐Y /☐ N	Pain In Jaw Joints	☐Y /☐ N
Artificial Heart Valve	☐Y /☐ N	Excessive Bleeding	☐Y /☐ N	Psychiatric Care	☐Y /☐ N
Artificial Joint	☐Y /☐ N	Excessive Thirst	☐Y /☐ N	Radiation Treatments	☐Y /☐ N
Asthma/emphysema	☐Y /☐ N	Fainting Spells/Dizziness	☐Y /☐ N	Rheumatic Fever	☐Y /☐ N
Blood Disease	☐Y /☐ N	Frequent Headaches	☐Y /☐ N	Rheumatism	☐Y /☐ N
Blood Transfusion	☐Y /☐ N	Heart Attack/Failure	☐Y /☐ N	Scarlet Fever	☐Y /☐ N
Breathing Problems	☐Y /☐ N	Heart Disease	☐Y /☐ N	Sickle Cell Disease	☐Y /☐ N
Bruise Easily	☐Y /☐ N	Hepatitis A, B or C	☐Y /☐ N	Stroke	☐Y /☐ N
Cancer	☐Y /☐ N	Herpes	☐Y /☐ N	Thyroid Disease	☐Y /☐ N
Chemotherapy	☐Y /☐ N	High Blood Pressure	☐Y /☐ N	Ulcers	☐Y /☐ N

Any other illness or conditions: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, Parent or Guardian Signature: ______________________________________ **Date:**______________________

Doctor Signature:____

Dental History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answer are for our records only and will be considered confidential.

Are you having any discomfort at this time? ☐Y /☐ N If yes, please explain: ____
Have you ever had any problems associated with previous dentistry? ☐Y /☐ N
Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
Date of your last dental visit? ______________________
Have you ever been treated for any type of gum problems? ☐ Y /☐ N
How often do you brush? ____________________________________ Brush is: ☐ Soft ☐ Medium ☐ Hard

Are you happy with the appearance of your teeth? ☐ Y /☐ N If no, what would you change? ___________________________
____

Do you have, or have you ever had any of the following?

Mouth Problems:		Teeth Problems:	
Bleeding/Sore gums	☐Y /☐ N	Loose Teeth	☐Y /☐ N
Unpleasant Taste/Bad Breath	☐Y /☐ N	Sensitive To Hot	☐Y /☐ N
Burning Tongue/Lips	☐Y /☐ N	Sensitive To Cold	☐Y /☐ N
Frequent blisters/Lips/Mouth	☐Y /☐ N	Sensitive To Sweets	☐Y /☐ N
Swelling/Lumps In Mouth	☐Y /☐ N	Sensitive To Biting	☐Y /☐ N
Ortho Treatment (braces)	☐Y /☐ N	Food Stuck In Teeth	☐Y /☐ N
Biting Cheeks/Lips	☐Y /☐ N	Clenching/Grinding	☐Y /☐ N
Clicking/Popping Jaw	☐Y /☐ N	Loose Denture	☐Y /☐ N
Difficulty Opening/Closing Jaw	☐Y /☐ N	Shifting In Bite	☐Y /☐ N
Headaches	☐Y /☐ N	Change In Bite	☐Y /☐ N

Do you use the following?

Brush	☐Y /☐ N	Fluoride Rinse	☐Y /☐ N
Dental Floss	☐Y /☐ N	Other	☐Y /☐ N

How would you rate your dental health? ☐ Excellent ☐ Good ☐ Poor

Any concerns or questions you have? ____

These are things that are important to me about my dental health: ____
____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes to my medical status. I understand that providing incorrect information can be dangerous to my health.

Patient, Parent or Guardian Signature: ____ **Date:** _________________

Print Name: ____

HIPAA Privacy Rule Of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment and Healthcare Operations (§164.508(a))

I, ___________________________, understand that as a part of my health, OC Perfect Smile maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to my health care.
- A security of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine health care operations such as assessing the quality and reviewing the competence of health care professionals.

I have been provided a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as a part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review the OC Perfect Smile notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for these purposes, and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review the OC Perfect Smile Notice of Information Practices prior to signing this consent.
- OC Perfect Smile reserves the right to change the notice and practices, and prior to implementation, will mail a copy of any revised notice to the address provided if requested.
- I have the right to object to the use of my health protected information for directory purposes.
- I have the right to request restrictions as to how my protected health information may be used or disclosed, to carry out treatment, payment, or healthcare operations, and that the OC Perfect Smile is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at anytime, except to the extent that the OC Perfect Smile has already taken action in reliance thereon.

Patient, Parent or Guardian Signature: ____

Printed Name of Patient, Parent or Guardian ____ **Date** ___________________